

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1302

02064

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County..... Talbot

City or town..... Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 minutes

Hospital, institution or street address where death occurred:

Eaton Memorial Hospital

How long in hospital or institution?..... 10 minutes

3. (a) FULL NAME

Mrs. W. Edgar Andrew

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

8. (b) Name of husband or wife..... Sarah Lane Andrews

7. Birth date of deceased (mo., day, yr.)..... Nov. 11, 1844

6. (c) If alive, give age..... 47 years

8. AGE: Years Months Days If less than one day
60 3 5 hrs. min.

9. Birthplace..... Caroline Co. Md.

(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... Arthur J. Andrew

13. Birthplace..... Caroline Co. Md.

14. Maiden name..... Sarah C. Lester

15. Birthplace..... Caroline Co. Md.

16. Informant..... Mrs. Sarah J. Andrew

Address..... Federalsburg Md.

17. Burial (Burial, cremation, or removal. Which?)..... Cemetery or crematory..... Hill Crest

Date thereof..... 2/20/45
(month) (day) (year)

Location..... Federalsburg Md.

18. Funeral director..... J. J. Trumpler & Son

Address..... Federalsburg, Maryland

19. Date rec'd by registrar..... 2/17/45 19. M.S. Registrar..... M. H. Nease

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Caroline

City or town..... Federalsburg (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 16, 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from February 12, 1945, to February 16, 1945,

and that I last saw h. m. alive on February 16, 1945.

Immediate cause of death..... Tremor & Convulsions

Decay of brain.

Due to..... Chronic Cardiac Disease

& Hypertension

Due to..... Arteriosclerosis

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

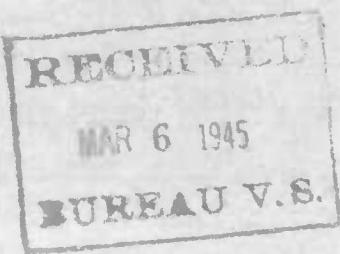
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other.....

Address..... Federalsburg, Maryland Date signed..... 2/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 29-2

02065

293
290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Talbot

near Cordova

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

near Lincolne

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fe Col. Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 27th 1904

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

40 6 15 hrs. min.

9. Birthplace

Westchester, Cordova, Md.

(Town, county, and state)

10. Usual occupation

House Work

11. Industry or business

James Bailey

Edward

James Bailey

Laura Van Zuid

Silsbee

Zuid

James Bailey

Cordova, Zuid

Burial

Date thereof 3-14-45

(Burial, cremation, or removal. Which?)

(Month) (day) (year)

Cemetery or crematory

Talbot Cemetery

Location

Near Cordova

18. Funeral director

J. Siegel Cremation & Burial

Address

Decatur, Ind.

19. Date rec'd by registrar

19-45

Date signed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Zuid

County

Talbot

City or town

Near Cordova

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

World

(If rural, give LOCATION)

Rural

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 15th 1945 at 9 A.M.

21. I CERTIFY that death occurred on the date above named, that I attended deceased from

Jan 31 1945 to Feb 12 1945
and that I last saw her alive on Feb 11 1945.

Immediate cause of death

Cerebral Hemorrhage (and 2-9-45)

DURATION

Dec 1944

Due to

Hemorrhage left

6 weeks

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results now

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

O. H. J. Siegel M.D.

M. D. or other

Address Redgely Md. Date signed 2-13-45

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. It is especially important.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 152

02066

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: *Talbot*

County

Easton, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

Life

Hospital, Institution or street address where death occurred:

Ctr. Dover and Dawson Sta.

How long in hospital or institution?

3. (a) FULL NAME

William Lester Ball

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**White**Married*

6. (b) Name of husband or wife

Stella Callaghan Ball

7. Birth date of deceased (mo., day, yr.)

March 3, 1885

6. (c) If alive, give age

47 years

8. AGE:

Years Months Days If less than one day

59 11 9

9. Birthplace

Easton, Md.

(Town, county, and state)

10. Usual occupation

Clark

11. Industry or business

Circuit Court of Talbot Co.

MOTHER FATHER

12. Name

William L. Ball

13. Birthplace

Maryland

14. Maiden name

Fannie Beck

15. Birthplace

Maryland

16. Informant

Mr. Steele & Ball (Wife)

Address

Easton, Md.

17. Burial

Date thereof

Feb. 14, 1945

(Burial/cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Spring Hill Cemetery

Location

Talbot, Md.

18. Funeral director

J. G. Clark

Address

Easton, Md.

19. Date rec'd by registrar

1945

Date signed

D. S. Neeris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Box 100, Dover and Dawson Sta.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

216-14-2948

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 12 1945 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw h.....alive on

1B.

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Belvoir

M. D. or other

Address

Easton, Md.

Date signed

2-13-45

RECEIVED

MAR 6 1945

BUREAU V.F.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 31-B

CERTIFICATE OF DEATH

02067

Reg. Dist. No. 290

1. PLACE OF DEATH:
 County Talbot
 City or town Frost (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months 2 days
 Hospital, institution, or street address where death occurred: Memorial Hospital
 How long in hospital or institution? 3 months 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MARYLAND County Talbot
 City or town Frost (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____ (If rural, give LOCATION)

3. (a) FULL NAME

Oscar W. Bagham

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Alberta J. Bagham

7. Birth date of deceased (mo., day, yr.) Aug. 27 1866 8. AGE: Years 84 Months 15 Days 5 It less than one day hrs. min.

9. Birthplace Quincy Ill. (Town, county, and state)

10. Usual occupation farmer

11. Industry or business William R. Bagham

12. Name William R. Bagham FATHER Ohio

13. Birthplace Massachusetts

MOTHER Maryland 14. Maiden name Mary 15. Birthplace Massachusetts

16. Informant B. Frank Benny

Address P.O. Box 4 Frost, Maryland Date thereof 2/5/45 (Burial, cremation, or removal, which?)

Cemetery or crematory Burial Date thereof 2/5/45 (month) (day) (year)

Location Frost, Maryland

18. Funeral director R. E. Clark Address Frost, Md.

19. 2/3 1945 (Date rec'd by registrar) H. H. Neerius Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1945 at 11 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 1944 to Feb 2 1945 and that I last saw him alive on Feb 2 1945

Immediata cause of death carcinoma of the prostate gland

Due to carcinoma of the prostate gland

Due to carcinoma of the prostate gland

Other conditions carcinoma of the prostate gland

(Include pregnancy within 8 months of death)

Major findings or operations carcinoma of the prostate gland Date of op. 1944 Anteopsy results dead Nov 4, 1944

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

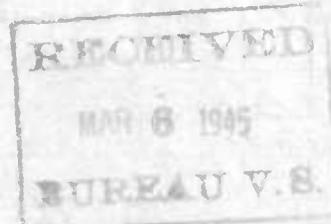
Means of injury Injured at work?

23. SIGNATURE John Schneide M.D. M. D. or other

Address Frost, Md. Date signed Feb 3, 1945

MEMORANDUM FOR THE CHIEF OF STAFF

ATTACHMENT



M
PLEASE WRITE PLAINLY, WITH
INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

02068

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot

City or town St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Norman J. Blader

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

Annie L. Wales

7. Birth date of deceased (mo., day, yr.)

Dec. 12 1862

8. (c) If alive, give age years

8. AGE:

82

Years

2

Month

11

Days

If less than one day

hrs.

min.

9. Birthplace

St. Michaels

(Town, county, and state)

10. Usual occupation

Oyster Packer

11. Industry or business

Benjamin H. Blader

FATHER

12. Name

St. Michaels

13. Birthplace

Emily Jane Robinson

14. Maiden name

Norchester Co. Md

15. Birthplace

Mrs Emma Sewell

16. Informant

St. Michaels. Md

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 26 1945

(month) (day) (year)

Cemetery

Location

St. Michaels. Md

Newman & Harrison

18. Funeral director

Address

St. Michaels. Md.

19. 76-24 1945 John H. Wales

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

Talbot

City or town St. Michaels

Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 23 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 23 1945 to Feb 23 1945

and that I last saw him alive on Feb 23 1945

Immediate cause of death

Coronary disease

Due to Arterio sclerosis

Due to Senility

Other conditions

(Incide pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

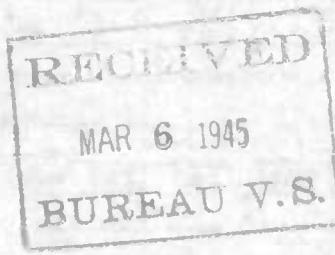
Injured at work?

23. SIGNATURE

M. D. or other

Address St. Michaels, Md. Date signed 2/24/45

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-12

02069

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH: Talbot
 County
 City or town Bozman
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary E Bridges

| | | |
|--------|------------------|--|
| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
| Female | white | widow |

8. (b) Name of husband or wife R Thomas Bridges7. Birth date of deceased (mo., day, yr.) April 29 1872 8. (c) If alive, give age years8. AGE: Years 72 Months 9 Days 4 If less than one day hrs. min.9. Birthplace Hanover Co Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER
 12. Name George Edmond
 13. Birthplace Richmond Va

MOTHER
 14. Maiden name Julia Frazer
 15. Birthplace West Virginia

16. Informant David Edmond
 Address Bozman Md

17. Burial Burial Date thereof Feb 5th 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Olivet Cemetery
 Location St Michaels Md

18. Funeral director Bozman and Harrison
 Address St Michaels Md

19. Feb 5- 1945 John H. Hurlas
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md County TalbotCity or town Bozman
 (If outside city or town limits, write RURAL and give nearest town)Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 2 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2 1945 to Feb 2 1945
 and that I last saw her alive on Feb 2 1945

Immediate cause of death

Chronic Respiratory

Due to

Due to

Arterio sclerosis

Other conditions

DURATION

7

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

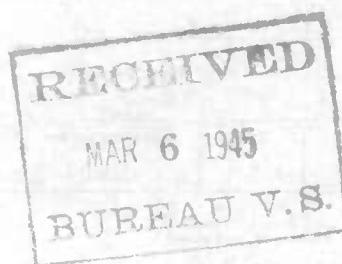
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. H. Hurlas MD
 M. D. or other
 Address St Michaels Md Date signed 2/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. It is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

02070

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:
County Falbot
City or town St. Michaels.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one hour

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

J. Harry Bryan

| | | |
|--------|------------------|--|
| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
| male | white | widowed |

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Aug 14 1870

8. (c) If alive, give age years

| | | | |
|---------------|--------|------|----------------------|
| 8. AGE: Years | Months | Days | If less than one day |
| 74 | 6 | 3 | hrs. min. |

9. Birthplace St. Michaels, Md.
(Town, county, and state)10. Usual occupation Waterman11. Industry or business James A. Bryan12. Name James A. Bryan
13. Birthplace Greens Annes Co. Md.14. Maiden name Annie R. Jones
15. Birthplace Caroline Co. Md.16. Informant R. N. BryanAddress St. Michaels, Md.17. Burial Date thereof Feb 20, 1945
(Burial, cremation, or removal. Which?)
(month) (day) (year)Cemetery or crematory Chest CemeteryLocation St. Michaels, Md.18. Funeral director Newman & HarrisonAddress St. Michaels, Md.19. Date rec'd by registrar Feb 1945 19.55 - John Howard
(Date rec'd by registrar) Local Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Md. County FalbotCity or town St. Michaels, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1945 at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1945 to Feb 17 1945
and that I last saw h. alive on Feb 17 1945

Immediate cause of death

Chronic Cardiac Asthma DURATION ?Due to Chronic Mitral Valvosis DURATION ?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

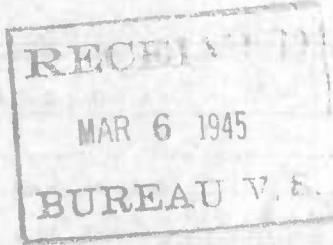
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE J. H. Hope, M.D. M. D. or otherAddress St. Michaels, Md. Date signed 2/18/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

CERTIFICATE OF DEATH

02071

Reg. Dist. No. 290

1. PLACE OF DEATH:

County *Talbot Co. Md.*
City or town *Baltimore Md. P.D. #1*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*MARY G. COPPER*4. Sex *Female* 5. Color or race *Colored* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Charles H. Copper*7. Birth date of deceased (mo., day, yr.) *June ? 1894* 8. (c) If alive, give age *59* years8. AGE: Years *50* Months *8* Days *?* If less than one day *hrs. 0 min.*9. Birthplace *Talbot Co. Md.* (Town, county, and state)10. Usual occupation *None*11. Industry or business *Domestic*12. Father *Harry Goldberg*13. Birthplace *Talbot Co. Md.*14. Maiden name *Mary Rose*15. Birthplace *Talbot Co. Md.*16. Informant *Charles Copper (Husband)*Address *Baltimore Md. P.D. #1*17. Burial Date thereof *Feb. 26, 1945*

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Copperville*Location *Baltimore Md. Rural*18. Funeral director *J. Ellis Clark*Address *Baltimore Md.*19. (Date rec'd by registrar) *2/26/45* (Date signed) *Feb. 26, 1945*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Talbot*City or town *Baltimore Md.* (If outside city or town limits, write RURAL and give nearest town)Street No. *Ellis #1 (Copperville)* (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH *February 22, 1945, at 11:30 P.M.*2f. I CERTIFY that death occurred on the date above stated; that I attended deceased from *February 22, 1945, to Feb. 22, 1945,* and that I last saw her alive on *Feb. 21, 1945,*Immediate cause of death *mitral regurgitation* DURATION *don't know*
Complications 3 days *know*Due to *do not know* *do not know*
Globar pneumonia *do not know*
Due to *do not know* *do not know*
From Feb. 10, 45 to Feb. 16, 45 *do not know*4g. Other conditions *Pleurisy Feb. 10 to*
Feb. 18, 45 (Include pregnancy within 3 months of death)

Major findings or operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

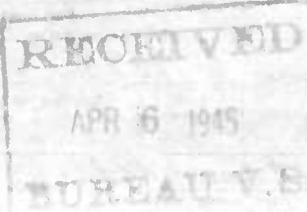
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *S. Orinny Willcox Jr. A.* M. D. or otherAddress *St. Michaels Md.* Date signed *Feb. 26, 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

02072

CERTIFICATE OF DEATH

Reg. Dist. No. 274

1. PLACE OF DEATH:

Talbot
Wittman

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Suzanne Louise Cummings

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1945

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

/ hrs. min.

9. Birthplace.....

Wittman

(Town, county, and state)

child

10. Usual occupation.....

11. Industry or business

12. Name

Nicholas Cummings

13. Birthplace

Baltimore, Md

14. Maiden name

Alice Jewell

15. Birthplace

Wittman, Md

16. Informant

J. N. Cummings

Address

Wittman, Md

17. Burial

Date thereof

Feb. 19, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery

Location

St. Michaels, Md

18. Funeral director

Neuman & Harran

Address

St. Michaels, Md

19. Date rec'd by registrar

Feb. 19, 1945

19. Date rec'd by registrar

Anna C. Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Talbot

City or town

Wittman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

✓

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 18

1945, at 7A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 18 1945 to Feb. 18 1945

and that I last saw her alive on Feb. 18 1945

Immediate cause of death

Congenital Deformity

Due to

Prematurity

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

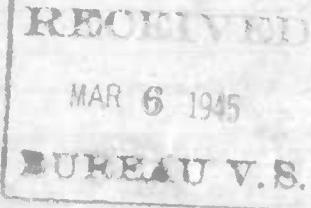
Injured at work?

23. SIGNATURE

Signature: Suzanne Cummings

M. D. or other

Address: Talbot, Md Date signed: Feb. 19, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

02073

Reg. Dist. No. 290

1. PLACE OF DEATH: Maryland
 County: Easton
 City or town: Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, Institution, or street address where death occurred:

 How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Talbot
 City or town: Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)
 2.(a) If veteran, name war: _____

3.(a) FULL NAME

Preston Henry Davidson

3.(b) Social Security Number

4. Sex: Male 5. Color or race: Black 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: _____ 6.(c) If alive, give age: _____ years

7. Birth date of deceased (mo., day, yr.): June 25, 1944

8. AGE: Years: 8 Months: _____ Days: _____ If less than one day: _____ hrs: _____ min: _____

9. Birthplace: Easton, Md.
 (Town, county, and state)

10. Usual occupation: _____

11. Industry or business: _____

FATHER
 12. Name: Alexander Lewis Davidson
 13. Birthplace: Easton, Md.

MOTHER
 14. Maiden name: Edith Chase
 15. Birthplace: Easton, Md.

16. Informant: Edith Davidson (Mother)
 Address: Easton

17. Burial: Burial Date thereof: Feb. 13, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Williamsburg Cemetery
 Location: Easton, R.D. Md.

18. Funeral director: Castle W. Whifford
 Address: Easton, Md.

19. (Date rec'd by registrar) 2/14/45 18 45 M.D. Maries
 (Date signed) 2/14/45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 19 45 at: _____

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from: _____ to: _____

and that I last saw h: _____ alive on: _____

Immediate cause of death: _____

Pneumo-pneumonia DURATION: _____

Due to: _____

Due to: _____

Other conditions: _____
 (Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op.: _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide: _____ Date of: _____

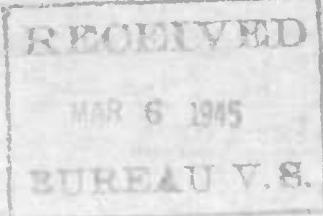
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: Lamir M. Wren, M.D. M. D. or other: _____

Address: Easton, Md. Date signed: 2/14/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

02074

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County Talbot
City or town Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 days 13 hrs.

Hospital, Institution, or street address where death occurred:

Bethel Hospital

How long in hospital or institution?

2 days 13 hrs.

3. (a) FULL NAME

Hattie D. Shields

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FemaleBlackMarried

6.(b) Name of husband or wife

John D. Shields42 Hammond St Easton6.(c) If alive, give age 62 years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

hrs. min.

9. Birthplace

Talbot Co. Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Linen & Linen

12. Name

Levy & Shields

13. Birthplace

Talbot Co. Md

14. Maiden name

Talbot Co. Md

15. Birthplace

Talbot Co. Md

16. Informant

John D. Shields

Address

Easton, Talbot Co. Md

17. Burial

Date thereofFeb 15 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Richardson

Location

Easton, Md

18. Funeral director

Jessie Stewart

Address

402 E Church St Salisbury MD

19.

2/121945D. H. Neelis

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty TalbotCity or town Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 Hammond Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 11 1945 at 2 30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 8 1945 to Feb 11 1945and that I last saw h. s. alive on Feb 10 1945

Immediate cause of death

Paraplegia Spastic

DURATION

Due to

Spina

13

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op. None

XO

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. Noble M.D.

M. D. or other

Address

Easton, MdDate signed 2/12/45

RECEIVED

MAR 6 1945

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4D

CERTIFICATE OF DEATH

Reg. Dist. No. 290

At Agnew 92175

1. PLACE OF DEATH:

County DelawareCity or town Delton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Franklin Swift Gibson4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Jane Evelyn (widow) Gibson7. Birth date of deceased (mo., day, yr.) Nov. 11, 1887 8. (c) If alive, give age 37 years8. AGE: Years 57 Months 2 Days 23 It less than one day hrs. 0 min.8. Birthplace Philadelphia, Penna. (Town, county, and state)10. Usual occupation Chemical Worker.11. Industry or business Franklin S. Gibson12. Name Franklin S. Gibson13. Birthplace Md.14. Maiden name Darcy C. Roeller Wilson15. Birthplace Pa.16. Informant Mrs. F. Swift GibsonAddress Delton, Md.17. Burial Date thereof Feb. 7, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Briar WoodsLocation Delton, Md.18. Funeral director Alton ClarkAddress Delton, Md.19. 2/6 19. 45 (Date rec'd by registrar) D. H. Nease Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County DeltonCity or town Delton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1945, at 2 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1945 to Feb. 7 1945and that I last saw him alive on Feb. 6 1945Immediate cause of death CoronaryOcclusionDue to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William S. Seymour M. D. or otherAddress Easton, Md. Date signed Feb. 16, 1945

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

02076

290

Reg. Dist. No.

1. PLACE OF DEATH:
County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 da.
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 da.

3. (a) FULL NAME

Gladys V. Hignutt

| | | |
|--------|------------------|---|
| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
| Female | White | — |

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1944 8. (c) If alive, give age years

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | 4 | 20 | | hrs. min. |

9. Birthplace Trappe Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Kenneth Hignutt13. Birthplace Wye Mills Md.14. Maiden name Helenetta Breen15. Birthplace St. L. Co. Md.16. Informant Kenneth HignuttAddress Trappe Md.17. Burial Burial Date thereof July 8-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ChestertieldLocation Centreville Maryland18. Funeral director Barton ThorAddress Centreville Maryland19. 2/7 19.45
(Date rec'd by registrar) N.L. Morris
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Talbot
City or town Trappe Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7- 1945 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated: the deceased was

Hele. 6 1945 to Hele. 9 1945 19.45and that I last saw her alive on Hele. 9 1945 19.45

Immediate cause of death.....

Pneumonia
Acute
Statis media

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

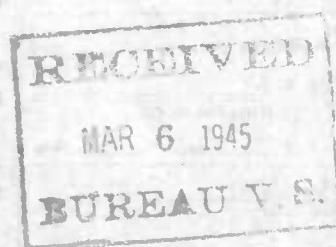
23. SIGNATURE Hilliard, Seymour

M. D. Father

Address Easton Md. Date signed Feb. 7/45

MEMORANDUM FOR THE CHIEF OF STAFF, UNITED STATES
ARMED FORCES

ATTACHMENT TO MEMORANDUM



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

02077

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Ella Haweck

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

B. (b) Name of husband or wife.....

Argah J. Haweck

.....(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

Mar. 23, 1882

8. AGE:

Years
64Months
11Days
5If less than one day
hrs.
min.

9. Birthplace.....

Filghamal Md.

(Town, county, and state)
Housewife

10. Usual occupation.....

John Edward Faulkner

11. Industry or business

MOTHER FATHER

12. Name.....

John Edward Faulkner

13. Birthplace

Filghamal Md.

14. Maiden name

Julia A. Phillips

15. Birthplace

Filghamal Md.

16. Informant

Mr. John Haweck

Address

Easton, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 23, 1945

(month) (day) (year)

Spring Hill

Cemetery or crematory

Location

Easton, Md.

18. Funeral director

Hawke & Stevens Son

Address

Easton, Maryland

19. Date rec'd by registrar

Feb 28' 1945

(Date rec'd by registrar)

J. C. Johnson

Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Talbot

City or town.....

Mystic

.....(If outside city or town limits, write RURAL and give nearest town)

Street No.....

.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 27 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 22 1945 to Feb 27 1945

and that I last saw her alive on Feb 27 1945

Immediate cause of death.....

coronary thrombosis

DURATION

6 days

Due to.....

Diabetes

10 yrs.

Other conditions

Hypertension

10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

no

Date of op.

Autopsy results.....

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

P. W. C. Stevens M.D.

M. D. or other

Address.....

Date signed

2-28-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02078

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

TALBOT CO.

County

Memorial Hospital,

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

(Hospital, institution, or street address where death occurred)

Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

William Hyde

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary J. Hyde

6. (c) If alive, give age 63 years

7. Birth date of

deceased (mo., day, yr.)

June 30, 1880

8. AGE:

Years
64Months
7Days
8

11 less than one day

hrs. min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial

(Burial, cremation, or removal. Write none)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Federalsburg

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Feb. 8-

1945

4 20/

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 7

1945

to

Feb. 8

1945

and that I last saw him alive on

Feb. 7

1945

to

Feb. 8

1945

Immediate cause of death

Cancer

decaying condition

DURATION

1 da.

Due to

Chronic Myositis

Due to

Bullock employment

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Lyon Baker M. D. or other

Address

Faston, Md. Date signed 2/9/45

RECEIVED

MAR 6 1945

LIBRARY U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

02079

CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH:

County TalbotCity or town Wittmane Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George D. Jackson

4. Sex

Male

5. Color or race

white married

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Ada M. Jackson

7. Birth date of deceased (mo., day, yr.)

Dec. 10 1861

B. (c) If alive, give age

76

years

8. AGE:

Years
83Months
1Days
21It less than one day
hrs. min.

9. Birthplace

Wittmane Md.

(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

Unknown

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

George S. Jackson

Address

Wittmane Md.

17. Burial

Date thereof Feb. 3, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Christ Cemetery

Location

St. Michaels Md

Funeral director

Newman & Harrison

Address

St. Michaels Md

18. Date rec'd by registrar

Feb. 3rd

19. Date signed

1945

Anna Carey Thomas

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md

County

Talbot

City or town

Wittmane

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 1 1945

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 31 to Feb. 1
and that I last saw him alive on Jan. 31

Immediate cause of death

coronary artery disease

DURATION

Due to

arterial sclerosis heart 1 year

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Gwynn Reeder

M. D. or other

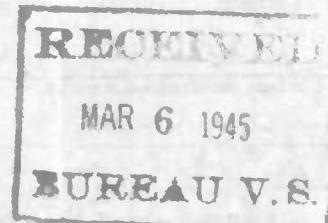
Address

Holmeswood

Date signed

RECEIVED BY THE UNITED STATES MARITIME

COMMISSION TO READ MESSAGES



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 562

02080

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot

City or town Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days 12 hrs. 45 Min.

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 11 days 12 hrs. 45 Min.

3. (a) FULL NAME

Lucille Jones

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Black Married

6.(b) Name of husband or wife John Wesley Jones

7. Birth date of deceased (mo., day, yr.) Jan. 26 1919

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
26

hrs. min.

9. Birthplace Kent Co. Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name James E Miller

13. Birthplace Md.

14. Maiden name Alphonso Trance

15. Birthplace Md.

16. Informant John L. Jones

Address Chesterlawn, Md.

17. Burial Date thereof Feb 10, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Greenlawn

Location Chesterlawn, Md. (Lawn)

18. Funeral director Harvey S. Williams

Address Chesertown, Md.

19. (Date rec'd by registrar) 2/9 1945

N. S. Neirne

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Kent

City or town Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 Cannon St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 28 1945 to Feb. 8 1945

and that I last saw her alive on Feb. 8 1945

Immediate cause of death Cardiac failure

DURATION

2 da

Due to Pituitary adenoma

7

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

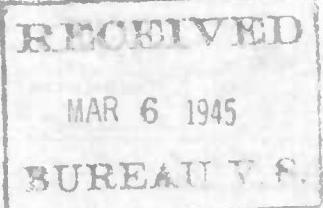
Injured at work?

23. SIGNATURE

J. Lynn Baker M.D.

M. D. or other

Address Jackson, Md. Date signed 2/8/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02081

108

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County *Saltat Co.*City or town *Easton, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 hrs. 45 min.*

Hospital, Institution, or street address where death occurred:

*Easton Memorial Hospital*How long in hospital or institution? *4 hrs. 45 min.*

3. (a) FULL NAME

Rahed Loveland

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male *White* Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Sept. 24, 1943*

6. (c) If alive, give age

years

8. AGE: Years *1* Months *6* Days *0* If less than one day

hrs. min.

9. Birthplace *Chester, Pa.*

(Town, county, and state)

10. Usual occupation */*

11. Industry or business

FATHER 12. Name *Robert J. Loveland*13. Birthplace *Chester, Pa.*MOTHER 14. Maiden name *Ruthie Johnson*15. Birthplace *Cordova, Md.*16. Informant *John & Clarence*Address *Chester, Pa.*17. Burial Date thereof *2/26/45*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Chester, Pa.*Location *Chester, Pa.*18. Funeral director *Wm. E. Neumann & Son*Address *Easton, Md.*19. *2/23* Date rec'd by registrar *1945*

M. D. or other

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Saltat*City or town *Cordova* (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *February 22 1945* at *4:30 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 21 1945 to *Feb. 22 1945*and that I last saw him alive on *Feb. 22 1945*Immediate cause of death *To + Davis*

DURATION

*1 day*Due to *In our car, involving three lots*

DURATION

1 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Dorothy E. Loveland M.A.* M. D. or otherAddress *Easton, Md.* Date signed *2/23/45*

RECEIVED
MAR 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02082

CERTIFICATE OF DEATH

Reg. Dist. No.

294

1. PLACE OF DEATH:

County..... Talbot
City or town..... Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Dorcas L. Mc. Quay

4. Sex..... Female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... widow

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Dec. 23, 1874 8. (c) If alive, give age..... years

8. AGE: Years..... 70 Months..... Days..... If less than one day..... hrs..... min.....

9. Birthplace..... Mc. Daniel Talbot Co. Md.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Thomas J. Kersey
13. Birthplace..... Mc. Daniel Talbot Co. Md.14. Maiden name..... Heater E. Vincent
15. Birthplace..... Bowman Talbot Co. Md.

16. Informant..... T. P. Kersey

Address..... Mc. Daniel, Md.

17. Burial..... Date thereof..... May 2, 1945
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery..... Cemetery
Location..... St. Michaels, Md.

18. Funeral director..... Neuman & Harrison

Address..... St. Michaels, Md.

19. Date rec'd by registrar..... May 10, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Talbot
City or town..... Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

FEBRUARY 28, 1945

20. DATE OF DEATH..... NOVEMBER 15, 1944

FEB. 28, 1945

and that I last saw her..... alive on FEB. 1, 1945

Immediate cause of death.....

Acute Coronary Disease

Due to..... Chr. Rheumatoid Arthritis

Due to.....

Other conditions..... Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations..... None

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... ✓

Date of..... ✓

Where did injury occur?..... ✓

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... ✓

Meane of injury.....

Injured at work?..... ✓

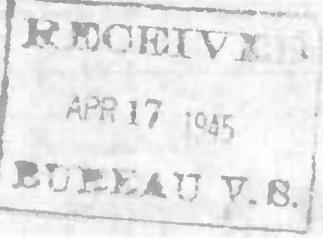
23. SIGNATURE..... Philip B. Brewster

M. D. or other

Address..... St. Michaels, Maryland

Date signed..... 3.2.45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8

02083

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County BaltimoreCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Easton Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

William Dorsey Meredith4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1944 6.(c) If alive, give age years8. AGE: Years 1 Months 1 Days 2 If less than one day hrs. min.9. Birthplace W. Queenstown Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name William E. Meredith13. Birthplace W. Queenstown, Md.14. Maiden name Mary Nelson15. Birthplace Rutherford, Md.16. Informant Wm. E. MeredithAddress Queen Anne Md17. Burial, cremation, or removal. Which? Burial Date thereof 2/21/45
(month) (day) (year)Cemetery or crematory ChestertownLocation Centerville Md18. Funeral director Barton BrosAddress Centreville, Md19. 2/19 1945 M.H. Series
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester Anne'sCity or town Centerville (If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 2-19 1945 at 3pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10, 1945, to Feb 19, 1945, and that I last saw him alive on Feb 19, 1945.Immediate cause of death Pneumonia Conuspiratus (56)
Duration 12 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations No op Date of op. 2/10Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

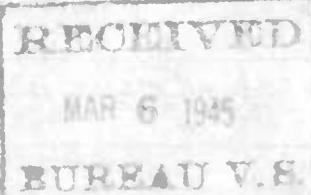
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE H. A. Hoble, M.D. M. D. or otherAddress Easton, Md. Date signed 2/21/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County: Eastern P.D.City or town: Eastern P.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred: Eastern P.D.

How long in hospital or institution?.....

3. (a) FULL NAME

Ronie Albion Mooney

4. Sex

m.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

A.

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec. 2nd 1944.

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

2 4

9. Birthplace: Eastern - A. D.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name: Philip Lee Mooney13. Birthplace: Md.14. Maiden name: Blanche P. Gilmer15. Birthplace: Md.16. Informant: Philip Lee MooneyAddress: Eastern Md. P.D.17. Burial: Burial(Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1945

(month) (day) (year)

Cemetery or crematory: OppenwillLocation: And Eastern - Md.18. Funeral director: Reili GumpAddress: Eastern Md.19. 2/6

19. 45

(Date rec'd by registrar)

D.H. Neeris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: EasternCounty: Md.City or town: Eastern P.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6

19. 45 at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death: Lobge pneumoniaDue to: Exposure

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the causes to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

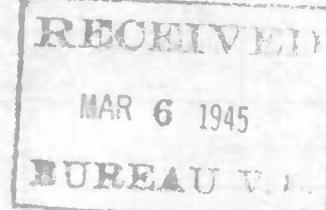
23. SIGNATURE: Landis W. Waltz, M.D.

M. D. or other

Address: Eastern Md.Date signed: 2-6-45

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25-2

02085

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County.....

City or town.....

Jacob Trappe (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. SEX

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Ange Hill Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name.....

MOTHER

13. Birthplace

14. Maiden name.....

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

Maryland County Jacob Trappe (Rural)

(If outside city or town limits, write RURAL and give nearest town)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 17

1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Set 16 - 1945 to Set 17 1945

and that I last saw him alive on Set 17 - 1945

Immediate cause of death.....

Barber's Decompenstation

DURATION

Inland

Due to.....

Death my own action

2

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

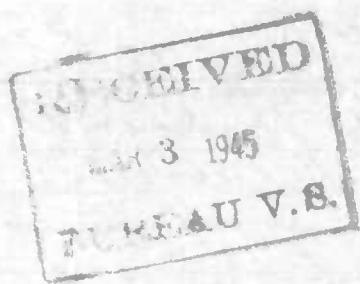
Joseph A. Ross

M. D. or other

Address.....

Trappe, Md.

Date signed Feb. 19 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Reg. Dist. No. 290

02086

1. PLACE OF DEATH:

County.....

Talbot
Md.

City or town.....

Easton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

20 yrs.

Hospital, institution, or street address where death occurred:

303 Redwood Ave.

How long in hospital or institution?.....

3. (a) FULL NAME

Ethel Thompson

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

John Thompson

7. Birth date of deceased (mo., day, yr.)

Nov. 1, 1880

6.(c) If alive, give age..... years

8. AGE:

64

Years

Months

Days

If less than one day

hrs.

min.

B. Birthplace.....

Somerset Co. Md.

(Town, county, and state)

10. Usual occupation.....

Stone Mason

11. Industry or business

George H. Davy

12. Name.....

George H. Davy

13. Birthplace

Somerset Co. Md.

14. Maiden name.....

Arabella Dodson

15. Birthplace

Virginia

16. Informant.....

Souther H. Davy

Address.....

Easton, Md.

17. Burial

Feb. 7, 1945

(Burial, cremation, or removal. Which?)

Date thereof.....

(month)

(day)

(year)

Cemetery or crematory.....

Spring Hill Cemetery

Location.....

Easton, Md.

18. Funeral director.....

P. Belis Clark

Address.....

Easton, Md.

19. Date rec'd by registrar.....

2/6 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Talbot

City or town..... Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 303 Redwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 4, 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb. 4, 1944, to Feb. 4, 1945

and that I last saw her alive on Jan. 29, 1945

Immediate cause of death.....

Auto Wreck or accident or fall down

DURATION

2 days

Due to..... Metastatic carcinoma

2 yrs.

Due to..... Carcinoma of both breasts, pleurisy, pneumonia

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. Taylor Baker M.D.

M. D. or other

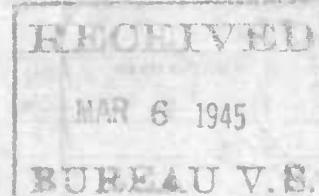
Address..... Easton

Date signed..... 2-6-45

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RECEIVED NO. 8745475

ATTACHED AND MAILED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth of deceased
is shown on
FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County..... Talbot
City or town..... St. Michaels, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Altha V. Watts

| | | |
|------------------|---------------------------|--|
| 4. Sex female | 5. Color or race white | 6. (a) Single, married, widowed, or divorced Single |
|------------------|---------------------------|--|

6. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.) Oct 10 + 1932

| | | | |
|---------------------|-------------|------------|---|
| 8. AGE: Years 12 | Months 3 | Days 18 | If less than one day hrs. min. |
|---------------------|-------------|------------|---|

9. Birthplace..... Tilghman
(Town, county, and state)

10. Usual occupation..... Child

11. Industry or business..... School

| | |
|--|----------------------------|
| MOTHER FATHER 12. Name..... Marion C. Watts | 13. Birthplace..... Newitt |
|--|----------------------------|

| | |
|--------------------------------------|----------------------------------|
| 14. Maiden name..... Altha L. George | 15. Birthplace..... Tilghman, Md |
|--------------------------------------|----------------------------------|

| | |
|------------------------------------|----------------------------------|
| 16. Informant..... Marion C. Watts | 17. Burial..... St. Michaels, Md |
|------------------------------------|----------------------------------|

| | |
|--------------|--------------------------------|
| Address..... | Date thereof..... Oct. 7, 1945 |
|--------------|--------------------------------|

| | |
|-----------------------------------|--|
| Cemetery or crematory..... Olivet | Date thereof..... (month) (day) (year) Burial, cremation, or removal. Which?) |
|-----------------------------------|--|

| | |
|--------------------------------|-------------------|
| Location..... St. Michaels, Md | Date thereof..... |
|--------------------------------|-------------------|

| | |
|---|-------------------|
| 18. Funeral director..... Munnam and Harrison | Date thereof..... |
|---|-------------------|

| | |
|-------------------------------|-------------------|
| Address..... St. Michaels, Md | Date thereof..... |
|-------------------------------|-------------------|

| | |
|--|-----------------------------|
| 19. Date rec'd by registrar..... Feb. 6 th 1945 | Date signed..... John Howes |
|--|-----------------------------|

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Talbot
City or town..... St. Michaels, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 5th 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on
February 5th 1945 to 1945
and that I last saw her alive on February 5th 1945Immediate cause of death..... Congenital
malformation heartDue to..... failure of valve function
ion.Due to..... aggravated by acute
cardiacitis

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

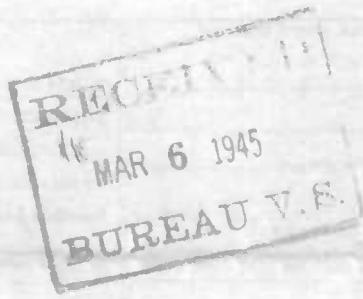
Injured at home, farm, industry, public place (where?)

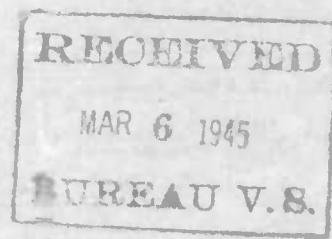
Means of injury..... Injured at work?

23. SIGNATURE..... John Howes, M.D.

M. D. or other

Address..... St. Michaels, Md Date signed..... Feb. 5 '45





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

02089

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County..... Talbot

City or town..... Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days.

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 19 days.

3. (a) FULL NAME

Mr. Joseph T, Windsor

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife..... Mrs. Minnie Windsor

7. Birth date of deceased (mo., day, yr.) April 23, 1864 64 years
6.(c) If alive, give age..... 64 years8. AGE: Years Months Days If less than one day
80 hrs. min.9. Birthplace..... Hurlock Maryland Dorchester Co.
(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... Hazleton Windsor

13. Birthplace..... Sharptown Maryland

14. Maiden name..... Phoebe Robinson

15. Birthplace..... Sharptown, Maryland

16. Informant..... Mr. Donald Wheatley

Address..... Rhodesdale, Maryland

17. Burial, cremation, or removal. Which? Date thereof..... 2-13-1945
(month) (day) (year)

Cemetery or crematory..... East New Market, Md.

Location.....

18. Funeral director..... Biggins Bros

Address..... Sharptown, Md.

19. 2/12 1945 M.H. Nease
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester

City or town..... Rhodesdale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 10, 1945

1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 22, 1945, to Feb 10, 1945

and that I last saw him alive on Feb 9, 1945

Immediate cause of death..... Pyelonephritis

DURATION

3 Wks.

Due to..... urinary obstruction

Due to..... Hypertrophied prostate

2 yrs

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations..... Hypertrophied prostate

Gland Date of op. Jan 30, 1945

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... John Schneider M.D.

M. D. or other

Address..... Cambridge, Md. Date signed Feb 10, 1945

